Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Aspirin use and discussion: percentage of members who are currently taking aspirin, including women 56 to 79 years of age with at least two risk factors for cardiovascular disease (CVD); men 46 to 65 years of age with at least one risk factor for CVD; and men 66 to 79 years of age, regardless of risk factors.

Source(s)

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 2, technical specifications for health plans. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 3, specifications for survey measures. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is one component of a two-part survey measure that assesses different facets of managing aspirin use for the primary prevention of cardiovascular disease. This measure uses survey data to assess the percentage of members who are currently taking aspirin, including women 56 to 79 years of age with at least two risk factors for cardiovascular disease; men 46 to 65 years of age with at least one risk

factor for cardiovascular disease; and men 66 to 79 years of age, regardless of risk factors.

This measure is collected as part of the CAHPS Health Plan Survey 5.0H, Adult Version (commercial, Medicaid) using a rolling average methodology.

See the related National Quality Measures Clearinghouse (NQMC) summary of the National Committee for Quality Assurance (NCQA) measure Aspirin use and discussion: percentage of women 56 to 79 years of age and men 46 to 79 years of age who discussed the risks and benefits of using aspirin with a doctor or other health provider.

Rationale

The United States Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (five-year risk greater than or equal to 3 percent) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy. The American Diabetes Association (ADA) encourages the use of aspirin therapy (75 to 162 mg/day) as a primary prevention strategy in patients with type 1 or type 2 diabetes who are at increased cardiovascular risk, including those who are 40 years of age and older or who have additional risk factors (e.g., family history of cardiovascular disease [CVD], hypertension, smoking, dyslipidemia, albuminuria).

In 2004, CHD was an underlying or contributing cause of death for 451,300 people and accounted for 1 of every 5 deaths in the United States (U.S.). The prevalence of CHD for both sexes in 2005 was nearly 16 million people, or 7.3 percent of the American population (American Heart Association [AHA], 2008). The cost of cardiovascular diseases and stroke in the U.S. for 2008 was estimated at $448.5 billion (AHA, 2008), including health expenditures and lost productivity resulting from morbidity and mortality (indirect costs). Evidence shows that age is a strong demographic factor for CHD. It is projected that by 2030, 1 in 5 Americans will be 65 or older. The need for CHD management is essential (AHA, 2008; Berra, Miller, & Fair, 2006).

Aspirin treatment has been shown to prevent one cardiovascular event over an average follow-up of 6.4 years. This means that, on average in a 6.4 year time period, the use of aspirin therapy results in a benefit of three cardiovascular events prevented per 1,000 women and four events prevented per 1,000 men (Berger et al., 2006). Aspirin has been shown to reduce CHD in patients with peripheral arterial disease, as well (Berger et al., 2006; Kikano & Brown, 2007).

Aspirin therapy (75 to 162 mg/day) is also recommended as a secondary prevention strategy in patients who have diabetes and a history of CVD.

Specifications are consistent with current recommendations from USPSTF and ADA.

Evidence for Rationale

American Heart Association. Heart disease and stroke statistics - 2008 update. Dallas (TX): American Heart Association; 2008. 43 p.

Berger JS, Roncaglioni MC, Avanzini F, Pangrazzi I, Tognoni G, Brown DL. Aspirin for the primary prevention of cardiovascular events in women and men: a sex-specific meta-analysis of randomized controlled trials. JAMA. 2006 Jan 18;295(3):306-13. PubMed

Berra K, Miller NH, Fair JM. Cardiovascular disease prevention and disease management: a critical role for nursing. J Cardiopulm Rehabil. 2006 Jul-Aug;26(4):197-206. [39 references] PubMed

Kikano GE, Brown MT. Antiplatelet therapy for atherothrombotic disease: an update for the primary

care physician. Mayo Clin Proc. 2007 May;82(5):583-93. [67 references] PubMed

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

Primary Health Components

Aspirin use; cardiovascular disease (CVD)

Denominator Description

The number of eligible members who responded to the survey and indicated that they did not have a health problem or take medication that makes taking aspirin unsafe, did not have an exclusion and who are:

Women age 56 to 79 with at least two risk factors for cardiovascular disease (CVD)
Men age 46 to 65 with at least one risk factor for CVD
Men age 66 to 79 regardless of the number of CVD risk factors

See the related "Denominator Inclusions/Exclusions" field.

Numerator Description

The number of members in the denominator who indicated that they currently take aspirin daily or every other day (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

A systematic review of the clinical research literature (e.g., Cochrane Review)

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Additional Information Supporting Need for the Measure

- Heart disease is the leading cause of death in the United States (Murphy, Xu, & Kochanek, 2013). Taking aspirin, when recommended by a provider, can prevent heart attack and stroke by thinning the blood to prevent blood clots from forming (American Heart Association, 2012).
- Cardiovascular disease cost the nation nearly $450 billion in 2010 in direct and indirect costs. Estimates suggest this number will rise to over $1 trillion by 2030 (Weintraub et al., 2011).
- Nearly 84 million (35.3 percent) American adults have cardiovascular disease (Go et al., 2014).
- On average, one death from cardiovascular disease occurs every 40 seconds (Go et al., 2014).
- Encouraging aspirin use can reduce heart disease and improve health outcomes in adults at risk for cardiovascular disease. Clinical guidelines recommend using aspirin to prevent and control heart

disease; however, it is important for providers and patients to discuss the risks and benefits of aspirin before starting a treatment plan (US Preventive Services Task Force, 2009; 2012 Writing Committee Members et al., 2012).

Evidence for Additional Information Supporting Need for the Measure

2012 Writing Committee Members, Jneid H, Anderson JL, Wright RS, Adams CD, Bridges CR, Casey DE, Ettinger SM, Fesmire FM, Ganiats TG, Lincoff AM, Peterson ED, Philippides GJ, Theroux P, Wenger NK, Zidar JP, Anderson JL, American College of Cardiology Foundation, American Heart Association Task Force on Practice Guidelines. 2012 ACCF/AHA focused update of the guideline for the management of patients with unstable angina/Non-ST-elevation myocardial infarction (updating the 2007 guideline and replacing the 2011 focused update): a report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines. Circulation. 2012 Aug 14;126(7):875-910. PubMed

American Heart Association (AHA). Aspirin and heart disease. [internet]. Dallas (TX): American Heart Association (AHA); 2012 Oct 2 [accessed 2014 Jun 03].

Go AS, Mozaffarian D, Roger VL, Benjamin EJ, Berry JD, Blaha MJ, Dai S, Ford ES, Fox CS, Franco S, Fullerton HJ, Gillespie C, Hailpern SM, Heit JA, Howard VJ, Huffman MD, Judd SE, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD, Mackey RH, Magid DJ, Marcus GM, Marelli A, Matchar DB, McGuire DK, Mohler ER, Moy CS, Mussolino ME, Neumar RW, Nichol G, Pandey DK, Paynter NP, Reeves MJ, Sorlie PD, Stein J, Towfighi A, Turan TN, Virani SS, Wong ND, Woo D, Turner MB, American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart disease and stroke statistics--2014 update: a report from the American Heart Association. Circulation. 2014 Jan 21;129(3):e28-292. PubMed

Murphy SL, Xu J, Kochanek KD. Deaths: final data for 2010. Natl Vital Stat Rep. 2013 May 8;61(4):1-117.

National Committee for Quality Assurance (NCQA). The state of health care quality 2015. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. 205 p.

US Preventive Services Task Force. Aspirin for the prevention of cardiovascular disease: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2009 Mar 17;150(6):396-404. PubMed

Weintraub WS, Daniels SR, Burke LE, Franklin BA, Goff DC Jr, Hayman LL, Lloyd-Jones D, Pandey DK, Sanchez EJ, Schram AP, Whitsel LP, American Heart Association Advocacy Coordinating Committee, Council on Cardiovascular Disease in the Young, Council on the Kidney in Cardiovascular Disease, Council on Epidemiology and Prevention, Council on Cardiovascular Nursing, Council on Arteriosclerosis, Thrombosis and Vascular Biology, Council on Clinical Cardiology, and Stroke Council. Value of primordial and primary prevention for cardiovascular disease: a policy statement from the American Heart Association. Circulation. 2011 Aug 23;124(8):967-90. PubMed

Extent of Measure Testing

All HEDIS measures undergo systematic assessment of face validity with review by measurement advisory panels, expert panels, a formal public comment process and approval by the National Committee for Quality Assurance's (NCQA's) Committee on Performance Measurement and Board of Directors. Where applicable, measures also are assessed for construct validity using the Pearson correlation test. All measures undergo formal reliability testing of the performance measure score using beta-binomial statistical analysis.

Evidence for Extent of Measure Testing

Rehm B. (Assistant Vice President, Performance Measurement, National Committee for Quality Assurance, Washington, DC). Personal communication. 2015 Mar 16. 1 p.

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Managed Care Plans

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Single Health Care Delivery or Public Health Organizations

Statement of Acceptable Minimum Sample Size

Specified

Target Population Age

Men 46 to 79 years of age; women 56 to 79 years of age

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Health and Well-being of Communities
Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Data Collection for the Measure

Case Finding Period

The measurement year

Denominator Sampling Frame

Enrollees or beneficiaries

Denominator (Index) Event or Characteristic

Clinical Condition

Patient/Individual (Consumer) Characteristic

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions
The number of eligible members who responded to the survey and indicated that they did not have a health problem or take medication that makes taking aspirin unsafe, did not have an exclusion, and who are:

Women 56 to 79 with at least two risk factors for cardiovascular disease (CVD)
Men 46 to 65 with at least one risk factor for CVD
Men 66 to 79 regardless of the number of CVD risk factors

Response choices must be as follows to be included in the denominator:

Do you take aspirin daily or every other day? = "Yes" or "No"
Do you have a health problem or take medication that makes taking aspirin unsafe for you? = "No"

Note:

Eligible Population: Men age 46 to 79 and women age 56 to 79 as of December 31 of the measurement year who were continuously enrolled during the measurement year (commercial) or for the last six months of the measurement year (Medicaid), and currently enrolled at the time the survey is completed.
Allowable Gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.
Each response choice below indicates a cardiovascular disease risk factor. Sum the responses by member to calculate the total number of risk factors for that member.
Do you now smoke cigarettes or use tobacco every, day some days or not at all? = "Every day" or "Some days"
Are you aware that you have any of the following conditions? Mark one or more. = "High cholesterol" or "High blood pressure" or "Parent or sibling with heart attack before the age of 60"
Refer to original measure documentation for additional information regarding eligibility.

Exclusions
Any response to the following question indicates a CVD exclusion:

Has a doctor ever told you that you have any of the following conditions? Mark one or more.

Exclude any member who selected *any* response choice: "A heart attack" or "Angina or coronary heart disease" or "A stroke" or "Any kind of diabetes or high blood sugar."

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions
The number of members in the denominator who indicated that they currently take aspirin daily or every other day

Member response choice must be as follows to be included in the numerator:

Do you take aspirin daily or every other day? = "Yes"

Exclusions
Unspecified

Numerator Search Strategy

Fixed time period or point in time

Data Source

Administrative clinical data

Patient/Individual survey

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Description of Allowance for Patient or Population Factors

This measure requires that separate rates be reported for commercial and Medicaid product lines.

Standard of Comparison

not defined yet

Identifying Information

Original Title

Aspirin use and discussion (ASP): aspirin use.

Measure Collection Name

HEDIS 2016: Health Plan Collection

Measure Set Name

Effectiveness of Care

Measure Subset Name

Measures Collected Through CAHPS Health Plan Survey

Submitter

National Committee for Quality Assurance - Health Care Accreditation Organization

Developer

National Committee for Quality Assurance - Health Care Accreditation Organization

Funding Source(s)

Unspecified

Composition of the Group that Developed the Measure

National Committee for Quality Assurance's (NCQA's) Measurement Advisory Panels (MAPs) are composed of clinical and research experts with an understanding of quality performance measurement in the particular clinical content areas.

Financial Disclosures/Other Potential Conflicts of Interest

In order to fulfill National Committee for Quality Assurance's (NCQA's) mission and vision of improving health care quality through measurement, transparency and accountability, all participants in NCQA's expert panels are required to disclose potential conflicts of interest prior to their participation. The goal of this Conflict Policy is to ensure that decisions which impact development of NCQA's products and services are made as objectively as possible, without improper bias or influence.

Adaptation

For commercial and Medicaid members, this measure is collected using the HEDIS (Healthcare Effectiveness Data and Information Set) version of the CAHPS survey (CAHPS Health Plan Survey 5.0H, Adult Version).

CAHPS 5.0 is sponsored by the Agency for Healthcare Research and Quality (AHRQ).

Date of Most Current Version in NQMC

2015 Oct

Measure Maintenance

Unspecified

Date of Next Anticipated Revision

Unspecified

Measure Status

This is the current release of the measure.

This measure updates previous versions:

National Committee for Quality Assurance (NCQA). HEDIS 2015: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2014. various p.
National Committee for Quality Assurance (NCQA). HEDIS 2015: Healthcare Effectiveness Data and Information Set. Vol. 2, technical specifications for health plans. Washington (DC): National Committee for Quality Assurance (NCQA); 2014. various p.
National Committee for Quality Assurance (NCQA). HEDIS 2015: Healthcare Effectiveness Data and Information Set. Vol. 3, specifications for survey measures. Washington (DC): National Committee for Quality Assurance (NCQA); 2014. various p.

Measure Availability

Source available for purchase from the National Committee for Quality Measurement (NCQA) Web site.

For more information, contact NCQA at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Phone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

Companion Documents

The following are available:

National Committee for Quality Assurance (NCQA). The state of health care quality 2015. Washington (DC): National Committee for Quality Assurance (NCQA); 2015 Oct. 205 p.
National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 2, technical update. Washington (DC): National Committee for Quality Assurance (NCQA); 2015 Oct 1. 12 p.

For more information, contact the National Committee for Quality Assurance (NCQA) at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Phone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org.

NQMC Status

This NQMC summary was completed by ECRI Institute on April 30, 2010.

This NQMC summary was updated by ECRI Institute on May 25, 2011, November 26, 2012, June 11, 2013, April 4, 2014, May 12, 2015, and again on February 19, 2016.

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Production

Source(s)

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 2, technical specifications for health plans. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 3, specifications for survey measures. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

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